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Issue Date: 16 August 2007

In the Matter of

D.R.H.¹
Claimant

Case No.: 2004 BLA 5607

v.

COWIN AND COMPANY, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Joseph E. Wolfe, Attorney
For the Claimant

Ms. Mary Lou Smith, Attorney
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER ON REMAND –
AWARD OF BENEFITS**

This matter involves a claim filed by Mr. D.H. for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 (“the Act”). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as “black lung” disease.

On May 26, 2004, based on my determination that Mr. H. had complicated pneumoconiosis, I concluded that he had established a change in a condition of entitlement previously adjudicated against him. Upon subsequent consideration of the entire record, I further

¹Chief Administrative Law Judge John Vittone has directed that I substitute initials for the names of the Claimant and all family members. Any comments or concerns regarding this mandated practice should be directed to Chief Administrative Law Judge John Vittone, 800 K Street, Suite 400N, Washington, D.C. 20001.

concluded that Mr. H. was totally disabled due to coal worker's pneumoconiosis and accordingly awarded black lung disability benefits.

The Employer appealed the award of benefits. On May 30, 2006, the Benefits Review Board ("BRB" and "Board") determined that I made several evidentiary admission errors. As a result, the BRB vacated my award and remanded the case for further adjudication consistent with its determinations.²

Procedural Background

In my May 26, 2004 decision, I previously summarized the procedural history of Mr. H's two claims, including the present claim which he filed in July 2002. After the BRB's remand, on April 30, 2007, I received a motion from Claimant's counsel to reopen the record for updated medical records. Since 20 C.F.R. § 725.310(b) precludes the initiation of a modification request before an administrative law judge, I denied the motion and provided the parties an opportunity to submit briefs considering the issues on remand. At the end of June and beginning of July 2007, the parties submitted their remand briefs.

Evidentiary Discussion

Effect of BRB Remand Decision

Upon its review of my May 2004 decision, the Board found several deficiencies in my evidentiary determinations.

Medical Opinion

In my decision and order, over Employer's objection and based on a 1987 BRB decision, I admitted Dr. Cherry's February 26, 2003 pulmonary evaluation and May 7, 2003 follow-up assessment, DX 12, previously submitted by a dismissed responsible operator. The BRB determined that under the new evidentiary restrictions, absent an evidentiary designation by a current party, Dr. Cherry's reports are not admissible. Since neither party has subsequently adopted Dr. Cherry's pulmonary assessments as part of its case-in-chief evidence, his two reports, DX 12, are now removed from my consideration.

Chest X-Rays

February 15, 2002 In the interest of due process, I admitted into evidence Dr. Scott's rebuttal interpretation of the February 15, 2002 treatment chest x-ray. However, based on its interpretation that the new evidentiary restrictions do not permit rebuttal evidence of treatment records, the BRB concluded my admission of Dr. Scott's interpretation was error. In compliance with the BRB remand order, I no longer admit Dr. Scott's interpretation, EX 2.

²I received the case file for re-adjudication in October 2006.

February 26, 2003 As part of Dr. Cherry's February 26, 2003 evaluation, Dr. Corea³ and Dr. Cherry⁴ interpreted a chest x-ray and I admitted their interpretations into evidence. However, for the reason noted above, since Dr. Cherry's examination is no longer admissible and has not been designated as a party's evidence, neither interpretation remains in evidence. Correspondingly, as indicated in the Employer's remand brief, since neither interpretation remains in the record, the Employer withdraws rebuttal interpretations of Dr. Scott and Dr. Wheeler of the February 26, 2003 chest x-ray, EX 5 and EX 6.

May 7, 2003 Since Dr. Richardson's interpretation of the May 7, 2003 film was obtained as part of Dr. Cherry's inadmissible second pulmonary evaluation, it is no longer in evidence.

Other Medical Evidence

Because the following two studies were obtained as part of Dr. Cherry's pulmonary evaluations, Dr. Corea's February 26, 2003 CT scan interpretation and the May 7, 2003 pulmonary function test are no longer part of the record.

Remand Designation of Evidence

On remand, the Employer has designated Dr. Wheeler's interpretations of the February 15, 2002⁵ and October 3, 2002 chest x-rays, EX 1 and EX 4, as its two case-in-chief chest x-rays. Accordingly, EX 1 and EX 4 are admitted into evidence.

Good Cause

On remand, the Employer seeks the admission of remaining chest x-ray interpretations⁶ for good cause due to their relevance in resolving significant issues in this case. Further, since the Employer is unable to rebut anything found in treatment records, the additional interpretations should be admitted in the "interest of justice." Although the Employer's points are well taken, the use of relevance and justice as standards in permitting good cause exceptions to the regulatory evidentiary restrictions imposed by the U.S. Department of Labor would effectively eliminate the mandated limitations. Consequently, I deny the Employer's good cause admission request.

Other Evidentiary Issues

Although not noted in my initial decision and order, I have discovered on remand two other evidentiary issues caused by the regulatory evidence restrictions.

³In my decision and order, I misspelled Dr. Corea's name as "Koren."

⁴In its remand decision, the BRB misidentified this interpretation as a reading by Dr. Patel.

⁵Although Dr. Wheeler designated February 12, 2002 as the date of the x-ray, the physician appears to be interpreting the February 15, 2002 study previously interpreted by Dr. Corea.

⁶Apparently EX 2, EX 5 and EX 6.

Chest X-Ray

During the initial adjudication of Mr. H.'s second claim, Claimant's counsel submitted a pulmonary evaluation by Dr. Rasmussen which contained an interpretation of an April 3, 2003 chest x-ray by Dr. Patel, DX 10. This interpretation was not related to the treatment of Mr. H. Subsequently, at the hearing, Claimant's counsel designated two chest x-ray interpretations by Dr. DePointe and Dr. Alexander, CX 1 and CX 2, as the Claimant's two permissible case-in-chief chest x-ray interpretations. Since 20 C.F.R. § 725.414(a)(2)(i) limits a claimant to two case-in-chief chest x-ray interpretations, and Dr. Patel's interpretation did not relate to Mr. H.'s treatment, his radiographic reading is not admissible in this case. Accordingly, I will not consider Dr. Patel's April 3, 2003 chest x-ray interpretation.

Medical Opinion

The inadmissibility of Dr. Patel's chest x-ray interpretation raises an additional legal concern about the associated pulmonary evaluation by Dr. Rasmussen, DX 10. As part of his complete examination, Dr. Rasmussen reviewed inadmissible Dr. Patel's x-ray report. However, the consideration of this inadmissible evidence is problematic because under 20 C.F.R. §§ 725.414(a)(2)(i) and 3(i) "any chest X-ray interpretation, pulmonary function test results, blood gas studies . . . and physician opinions that appear in a medical report must each be admissible" under the regulations. When confronted with a medical opinion that contained evidence not admitted into the formal record, the BRB in *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006) (en banc) indicated that an ALJ may: a) exclude the report, b) redact the objectionable content, c) require a revised report, or d) consider the physician's reliance on the inadmissible evidence in deciding the probative value of the report.

For Dr. Rasmussen's April 3, 2003 pulmonary evaluation report, DX 10, I will apply a combination of the second and fourth options. First, I will not use the inadmissible chest x-ray interpretation referenced by Dr. Rasmussen. Second, while most portions of his pulmonary assessment remain viable, Dr. Rasmussen's diagnosis of complicated coal workers' pneumoconiosis has diminished probative value because he relied solely on Dr. Patel's inadmissible chest x-ray interpretation for his finding and did not review any other admissible radiographic evidence that would otherwise support his conclusion.

Summary

Since the BRB affirmed the remainder of my evidentiary rulings and in light of the above determinations, my decision on this remand is based on the hearing testimony and the following exhibits: DX 1 to DX 10 (with the exception of Dr. Patel's chest x-ray interpretation), DX 11, DX 13 to DX 34, CX 1 to CX 5, EX 1, EX 3, and EX 4.

REMAND ISSUES

1. Whether, in filing a subsequent claim on July 15, 2002, Mr. H. demonstrated that a change has occurred in one of the conditions, or elements, of entitlement, upon which the affirmed denial of his prior claim was based in January 2000.
2. If Mr. H. establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Findings

Born on October 28, 1950, Mr. H. married Mrs. C.H. on October 27, 1973; they currently live together. He first worked in the coal mines in 1975 and continued until his last coal mine employment in 1993, totaling 18 years of coal mine employment. Mr. H. stopped mining coal when a doctor told him he could no longer work in the mines.⁷ In his last position as a coal miner, Mr. H. worked underground as a miner driller, sinking a ventilation shaft and building brattices. This job required him to drill from the top of the mine to the bottom through hard rock and coal seams. He also occasionally shoveled the beltline, operated equipment, roof bolted and did other tasks except run the miner. Mr. H.'s regular work required him to lift jacks weighing 150 to 200 pounds (DX 1, DX 3, DX 7 and TR, p. 27 - 42).

Mr. H. began experiencing breathing problems in 1992. Presently, he is unable to do any physical work and cannot carry 50 pounds. Mr. H. is treated for his breathing problems with breathing pills and inhalers in addition to using a breathing machine. Mr. H. never smoked cigarettes. Mr. H. has not been gainfully employed since he left the coal mines in 1993 (TR, p. 42 - 46, DX 1).

Affirmed Findings

In its remand decision, the BRB affirmed as unchallenged my determinations that Mr. H. had eighteen years of coal mine employment and Cowin and Company, Inc., is the responsible operator.

Issue # 1 - Change in Applicable Condition of Entitlement

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim. 20 C.F.R. § 725.309(c) and 20 C.F.R. § 725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a subsequent claim which will be considered under the provisions of 20 C.F.R. § 725.309(d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of

⁷Since the coal mine in which Mr. H. last worked was located in Alabama, this case falls within the jurisdiction of the U.S. Court of Appeals for the Eleventh Circuit (TR, pages 35 and 36).

entitlement”) has changed and is now present. If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309(d)(4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

In adjudicating a subsequent claim by a living miner in which the applicable conditions of entitlement relate to the miner’s physical condition, I focus on the four basic conditions, or elements, a claimant must prove by preponderance of the evidence to receive black lung disability benefits under the Act. First, the miner must establish the presence of pneumoconiosis.⁸ Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner’s pneumoconiosis arose, at least in part, out of coal mine employment.⁹ Third, the miner has to demonstrate he is totally disabled.¹⁰ And fourth, the miner must prove the total disability is due to pneumoconiosis.¹¹

With those four principal conditions of entitlement in mind, the next adjudication step requires the identification of the conditions of entitlement a claimant failed to prove in the prior claim. In that regard, of the four principal conditions of entitlement, the two elements that are usually capable of change are whether a miner has pneumoconiosis or whether he is totally disabled. *Lovilia Coal Co. v. Harvey*, 109 F.3d 445 (8th Cir. 1997). That is, the second element of entitlement (pneumoconiosis arising out of coal mine employment) and the fourth element (total disability due to pneumoconiosis) require preliminary findings of the first element (presence of pneumoconiosis) and the third element (total disability).

In his first claim, Judge Kichuk’s affirmed denial was based on Mr. H.’s failure to establish the presence of pneumoconiosis. Since the record closed in that claim in September 1996, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since 1996 to determine whether Mr. H. can now prove the presence of pneumoconiosis.

⁸20 C.F.R. § 718.202.

⁹20 C.F.R. § 718.203(a).

¹⁰20 C.F.R. § 718.204(b).

¹¹20 C.F.R. § 718.204(a).

Presence of Pneumoconiosis

“Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment.¹² The regulatory definitions include both clinical, or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as “any chronic lung disease arising out of coal mine employment.”¹³ Clinical, or medical, pneumoconiosis includes those conditions “characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment.” The definition includes a finding of anthrasilicosis, anthracosis, massive pulmonary fibrosis and silicosis or silicotuberculosis, which arise out of coal mine employment. The regulation further indicates that a lung disease arising out of coal mine employment includes “any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” 20 C.F.R. § 718.201(b). As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202(a)(1)), autopsy or biopsy report (§ 718.202(a)(2)), regulatory presumption (§ 718.202(a)(3)),¹⁴ and medical opinion (§ 718.202(a)(4)). Since obviously an autopsy report has not been submitted, Mr. H. will have to rely on regulatory presumption related to the presence of complicated pneumoconiosis, chest x-rays, biopsy report, or medical opinion to establish the presence of pneumoconiosis.

Regulatory Presumption - Complicated Pneumoconiosis

The regulation, in part, at 20 C.F.R. § 718.304, provides that if a claimant is able to establish the presence of complicated pneumoconiosis, then an irrebuttable presumption of total disability due to pneumoconiosis is established. In the Black Lung Benefits Act, 30 U.S.C. 921(c)(3)(A) and (C), as implemented by 20 C.F.R. § 718.304(a), Congress determined that if a miner is suffering from a chronic dust disease of the lung “which when diagnosed by chest roentgenogram, yields one or more large opacities (greater than one centimeter in diameter) and would be classified in category A, B, or C...there shall be an irrebuttable presumption that he is totally disabled by pneumoconiosis...”¹⁵ This type of large opacity is called “complicated

¹²20 C.F.R. § 718.201(a).

¹³20 C.F.R. § 718.201(a)(1) and (2) (emphasis added).

¹⁴If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202(a)(3), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

¹⁵On the standard ILO chest x-ray classification worksheet, Form CM 933, large opacities are characterized by three sizes of opacities, identified by letters. The interpretation finding of Category A indicates the presence of a large opacity having a diameter greater than 10 mm (one centimeter) but not more than 50 mm; or several large opacities,

pneumoconiosis.” 20 C.F.R. §§ 718.304(b) and (c) also permits complicated pneumoconiosis to be established by either the presence of massive fibrosis in biopsy and autopsy evidence or other means which would be expected to produce equivalent results in chest x-rays or biopsy/autopsy evidence.

All evidence relevant to whether the miner has complicated pneumoconiosis must be weighed. *Melnick v. Consolidation Coal Co.*, 16 B.L.R. 1-31 (1991); *Maypray v. Island Creek Coal Co.*, 7 B.L.R. 1-683 (1985). Therefore, even after the presence of large opacities have been established through one of the methods set out in § 718.304, all other medical evidence must be considered and evaluated to determine if relevant evidence conflicts with or confirms a finding of large opacities and complicated pneumoconiosis. For example, the BRB affirmed a finding of complicated pneumoconiosis under 20 C.F.R. §718.304 when the administrative law judge considered chest x-rays in conjunction with CT-scan findings to determine there was sufficient evidence to find complicated pneumoconiosis. *Keene v. G&A Coal Co.*, BRB No. 96-1689 BLA (Sept. 27, 1996) (unpub.). And, in another case, despite radiographic evidence of large opacities, the U.S. Court of Appeals for the Sixth Circuit upheld a determination that complicated pneumoconiosis did not exist based on probative autopsy evidence indicating the lesions were not complicated pneumoconiosis. *Gray*, 176 F.3d at 388.

In light of these statutory, regulatory and judicial principles, the adjudication of whether a claimant is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 involves a three step process. First, I must determine whether: a) the preponderance of the chest x-rays establishes the presence of large opacities characterized by size as Category A, B, or C under recognized standards; or b) biopsy evidence shows massive fibrosis; or c) other diagnostic results exist which are equivalent to the requisite chest x-ray or biopsy evidence of large opacities.

Second, if radiographic, biopsy or other equivalent evidence of large opacities exists, I must evaluate all the other relevant evidence in the record to determine whether it confirms or contradicts the presence of large opacities. In other words, I must assess whether the preponderance of the entire evidentiary record establishes the presence of large pulmonary opacities.

Third, if the preponderance of the evidence demonstrates the existence of large opacities, I must then consider all other relevant evidence to determine whether that evidence contradicts or supports a finding that the large opacities are indicative of complicated pneumoconiosis.

Existence of Large Opacities

Mr. H. must rely on chest x-ray imaging, biopsy result or other medical tests, such as CT scans, showing the equivalent of a radiographic image, to establish the presence of large opacities.

each greater than 10 mm but the diameter of the aggregate does not exceed 50 mm. Category B mean an opacity, or opacities “larger or more numerous than Category A” whose combined area does not exceed the equivalent of the right upper zone of the lung. Category C represents one or more large opacities whose combined area exceeds the equivalent of the right upper zone.

Chest X-Rays

Date of x-ray	Exhibit	Physician	Interpretation
Feb. 15, 2002	CX 5	Dr. Ebeo	Findings consistent with marked amount of fibrosis from sarcoidosis with evidence of pulmonary fibrosis.
(same)	EX 1	Dr. Wheeler, BCR, B ¹⁶	Negative for pneumoconiosis, profusion 0/1, ¹⁷ type q/t opacities. ¹⁸ 9 cm masses in right upper lung and left lower lung and 7 x 3 cm mass right mid lung “compatible with conglomerate granulomatous disease or large opacities of CWP (coal workers’ pneumoconiosis).” Minimal to moderate small nodular infiltrates compatible with TB or histoplasmosis, “and some nodules could be CWP.”
October 3, 2002	DX 9	Dr. Forehand, B	Positive for pneumoconiosis, profusion 1/1, type q opacities, category B large opacity of complicated pneumoconiosis; bilateral upper zone masses; (Rule out tuberculosis (TB) and malignancy).
(same)	EX 3	Dr. Scott, BCR, B	Positive for pneumoconiosis, profusion 1/1, category C large opacity; “all changes could be due to TB, unknown activity.”

¹⁶B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A “B Reader” has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A “Board Certified Radiologist” has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

¹⁷The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

¹⁸There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

(same)	EX 4	Dr. Wheeler, BCR, B	Positive for pneumoconiosis, profusion 1/1, ¹⁹ type q opacities. ²⁰ Questionable large pulmonary opacities consistent with pneumoconiosis. 9 cm masses in right upper lung and left lower lung and 7 x 3 cm mass right mid lung “compatible with conglomerate granulomatous disease or large opacities of CWP (coal workers’ pneumoconiosis).” Minimal to moderate small nodular infiltrates compatible with TB or histoplasmosis, “and some nodules could be CWP.”
November 24, 2003	CX 5	Dr. Mehta	No hilar lymphadenopathy, bilateral upper lobe fibrosis with some pneumonia like changes and bronchioectasis, findings consistent with sarcoidosis and/or pneumoconiosis.
Dec. 8, 2003	CX 2	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion 2/2, type r/q opacities, Category C large opacity of complicated pneumoconiosis; areas of coalescence present bilaterally, bilateral large opacities in both upper zones and in right mid-upper zone. These areas of progressive massive fibrosis constitute complicated CWP.
(same)	CX 1	Dr. DePonte, BCR, B	Positive for pneumoconiosis, profusion 2/1, type q opacities, category C large opacity.

Of the four most recent chest x-rays, there is no dispute concerning three of the studies. The October 3, 2002 and December 8, 2003 films are positive for the presence of a large opacity. Conversely, Dr. Mehta did not report finding a large pulmonary opacity in the November 24, 2003 chest x-ray.

In the remaining film developed on February 15, 2002, Dr. Ebeo observed “marked amount” of fibrosis but did not specify the size of the nodules or use an ILO classification. On the other hand, Dr. Wheeler noted the presence of three large pulmonary opacities measuring greater than 1 cm. Since Dr. Wheeler is a dual qualified radiologist, I give his interpretation greater probative weight. As a result, the February 15, 2002 chest x-ray also shows the presence of a large pulmonary opacity.

¹⁹The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Additionally, according to 20 C.F.R. § 718.102 (b), a profusion reading of 0/1 does not constitute evidence of pneumoconiosis.

²⁰There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

Since three of the four recent chest x-rays (February 15, 2002, October 3, 2002, and December 8, 2003) show the presence of a large opacity, I find the preponderance of the radiographic evidence establishes the existence of large opacities.

Confirmation of the Presence of Large Pulmonary Opacities

Very little evidence in the record suggests the observed opacities are not actually present. In fact, as set out in the discussion of the CT scans, other probative evidence establishes that the large opacities on the x-ray films represent actual large masses in Mr. H.'s lungs. Consequently, Mr. H. has definitively established the presence of a large pulmonary opacity in his lungs through chest x-rays which is a requirement of 20 C.F.R. § 718.304(a) for the invocation of the irrebuttable presumption of total disability due to pneumoconiosis.

Other Medical Evidence

Since Mr. H. has proven the existence of a large pulmonary opacity, I move to the third adjudicative step and consider other relevant medical evidence prior to making a determination of whether Mr. H. has invoked the 20 C.F.R. § 718.304 presumption through the presence of complicated pneumoconiosis. At this stage, I consider all other medical evidence to determine if it conflicts with or confirms a finding that the large opacities are related to the presence of complicated pneumoconiosis. In Mr. H.'s case, the "other" medical evidence has six components: A) CT scan interpretations; B) lung biopsy; C) pulmonary function tests; D) arterial blood gas studies; E) medical opinion based on evaluation and treatment; and, F) physician x-ray comments.

A. CT Scans (CX 5)

February 27, 2002 According to Dr. Stacy Stevens, the CT scan of February 27, 2002 was consistent with changes from sarcoidosis with marked amount of pulmonary fibrosis. Dr. Stevens noted that the only portion of the lungs spared were the lung bases and most superior aspect of lung apices.

December 1, 2003 Dr. Kelly Gunter read another CT scan taken of Mr. H. on December 1, 2003 and compared it to the study from February 27, 2002. Dr. Gunter observed "consolidative masses" consistent with extensive fibrosis. Dr. Gunter also noted that since the previous exam, there had been progression of the reticular nodular pattern involving the periphery of the lungs. The perihilar masses are consistent with extensive fibrosis. The moderate increase in reticular nodular pattern was consistent with interstitial disease.

Dr. Stevens identified sarcoidosis in the CT study; Dr. Gunter did not mention sarcoidosis as a finding. This interpretative standoff does not present sufficient contrary evidence that the large pulmonary opacities are not due to complicated pneumoconiosis. Further, in the comparison of the CT scan images, Dr. Gunter noted that Mr. H.'s pulmonary fibrosis progressed over time. By the time of the December 2003 CT scan, the fibrotic changes showed a

progression of the reticulonodular pattern, which is consistent with the progressive nature of pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(c). Accordingly, I find the CT scan interpretations do not sufficiently contradict a finding of complicated pneumoconiosis.

B. Lung Biopsy (CX 5)

On January 14, 2004, Dr. David Soike, board certified in anatomic pathology and clinical pathology,²¹ evaluated several tissue samples from Mr. H.'s lungs and associated lymph nodes. The largest lung tissue sample size had an aggregate size of 1.5 x 0.5 x 1 centimeters. The pulmonary lymph nodes did not contain any tumors and were anthracotic and benign. The tissue samples from the right upper lobe showed increased interstitial fibrosis with a moderate number of macrophages. In those lung tissue samples, Dr. Soike specifically highlighted the absence of any granulomas or "active fibrogenesis."

Dr. Soike's finding of anthracotic pulmonary lymph nodes and interstitial fibrosis with macrophages does not represent evidence contrary to a finding of complicated pneumoconiosis in Mr. H.'s lungs. His specific negative findings for granulomas and active fibrogenesis also help eliminate those ailments as possible causes of the large pulmonary opacities.

C. Pulmonary Test Results

Exhibit	Date / Doctor	Age / Height	FEV ¹ pre ²² post ²³	FVC pre post	MVV pre post	% FEV ¹ / FVC pre post	Qualified ²⁴ pre Post	Comments
CX 5	March 4, 2002 Dr. Mehta	51 71.0"	1.37 1.68	2.44 2.59	45 49	56.1% 64.9%	Yes ²⁵ Yes	Probable restriction, possible obstruction
DX 9	October 3, 2002 Dr. Forehand	51 70.0"	1.81 2.06	3.18 3.41	47 63	56.9% 60.4%	Yes ²⁶ Yes	Obstructive ventilatory pattern

²¹As I informed the parties at the hearing (TR, p. 8), I take judicial notice of Dr. Soike's board certification and have attached the certification documentation.

²²Test result before administration of a bronchodilator.

²³Test result following administration of a bronchodilator.

²⁴Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal to or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

²⁵The qualifying FEV1 number is 2.27 for age 51 and 70.9"; the corresponding qualifying FVC and MVV values are 2.86 and 91, respectively.

²⁶The qualifying FEV1 number is 2.17 for age 51 and 69.7"; the corresponding qualifying FVC and MVV values are 2.74 and 87, respectively.

DX 10	April 3, 2003 Dr. Rasmussen	52 69.0"	1.51 1.71	2.96 3.22	46 62	51.0% 53.1%	Yes ²⁷ Yes	Mild airway obstruction
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The apparently valid and conforming pulmonary function tests evidence demonstrate Mr. H. has a totally disabling pulmonary impairment. These un-contradicted studies independently support a finding that Mr. H. is totally disabled due to a pulmonary impairment which is not inconsistent with the invoked presumption of total disability due to the presence of complicated pneumoconiosis.

D. Arterial Blood Gas Studies

Exhibit	Date / Doctor	pCO ₂ (rest) pCO ₂ (exercise)	pO ₂ (rest) pO ₂ (exercise)	Qualified ²⁸	Comments
DX 10	April 3, 2002 Dr. Rasmussen	39	75	No ²⁹	
DX 9	October 3, 2002 Dr. Forehand	39	82	No	Valid. ³⁰

Although none of Mr. H.'s arterial blood gas studies similarly establish total disability, those non-qualifying tests measure only one aspect of Mr. H.'s respiration capacity. As a result, the arterial blood gas studies impeach neither the total disability established by the pulmonary function tests nor a determination that the large opacities in Mr. H.'s lungs represent complicated pneumoconiosis.

E. Medical Opinions

Dr. Randolph Forehand
(DX 9)

On October 3, 2002, Dr. Forehand, board certified in pediatrics, allergy and immunology,³¹ conducted a pulmonary evaluation of Mr. H. who reported productive cough, wheezing, and dyspnea. Mr. H. has a coal mine employment history of about 19 years, 13 of which were underground. He never smoked cigarettes. In the chest x-ray, Dr. Forehand observed large opacities consistent with complicated coal workers' pneumoconiosis. The pulmonary function test revealed an obstructive ventilatory pattern and the arterial blood gas

²⁷The qualifying FEV1 number is 2.10 for age 52 and 68.9"; the corresponding qualifying FVC and MVV values are 2.64 and 84, respectively.

²⁸To qualify for Federal Black Lung Disability benefits at a coal miner's given pCO₂ level, the value of the coal miner's pO₂ must be equal to or less than corresponding pO₂ value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

²⁹For the pCO₂ of 39, the qualifying pO₂ is 61, or less.

³⁰Dr. John Michos certified the test results as valid on October 29, 2002.

³¹I take judicial notice of Dr. Forehand's board certification and have attached the certification documentation.

study produced normal results. Upon chest exam, Dr. Forehand observed scattered crackles heard at bases. Based on the radiographic evidence of larger opacities and Mr. H.'s coal dust exposure, Dr. Forehand diagnosed complicated pneumoconiosis. He also indicated that tuberculosis and malignancy should be ruled out. Dr. Forehand believed Mr. H. has a significant respiratory impairment and is unable to return his last coal mine job or similar work. The physician determined Mr. H. to be totally disabled from a respiratory standpoint and opined that the coal workers' pneumoconiosis is the "sole factor" contributing to his respiratory impairment.

Dr. Donald Rasmussen
(DX 10)

On April 3, 2003, Dr. Rasmussen, board certified in internal medicine, conducted a pulmonary evaluation of Mr. H., who reported shortness of breath with exertion over the past 10 to 12 years, significant dyspnea when climbing one flight of stairs, chronic productive cough and wheezing at night and with exertion. Mr. H. had a medical history of chronic bronchitis and asthma. He is a non-smoker and worked in the coal mines for 19 years. His last coal mine employment occurred in 1993.

A chest exam revealed breath sounds that were tubular in upper zones and moderately to markedly reduced in lower zones. A B-reading chest x-ray interpretation by Dr. Patel showed the presence of pneumoconiosis with category C large opacities. The pulmonary studies revealed severe, slightly reversible restrictive and obstructive ventilatory impairment and maximum breathing capacity was markedly reduced with significant improvement after bronchodilator. Mr. H.'s total lung capacity and single breath carbon monoxide were minimally reduced.

Dr. Rasmussen opined that Mr. H. suffers a marked loss of lung function and does not retain the pulmonary capacity to perform his last regular coal mine employment with required heavy and very heavy manual labor. Mr. H.'s significant history of coal dust exposure and x-ray changes consistent with complicated pneumoconiosis lead Dr. Rasmussen to conclude that Mr. H. has complicated pneumoconiosis from coal mine employment. His only risk factor for a totally disabling respiratory insufficiency is coal dust with resultant progressive massive fibrosis.

Dr. Jay Mehta and Dr. Harsha Shantha
Pulmonary Associates of East Tennessee
(CX 5)

In March 2001, Mr. H. presented to Dr. Mehta with episodes of dyspnea. The chest examination of his chest proved unremarkable. The physician diagnosed sarcoidosis, occupational disease or pneumoconiosis with chronic obstructive pulmonary disease.

On February 15, 2002, Dr. Mehta again evaluated Mr. H. who complained of shortness of breath with sputum and wheezing. A physical exam of the chest was normal. Dr. Mehta concluded that Mr. H. had sarcoidosis, pneumoconiosis, and mild COPD/asthma.

On March 18, 2002, Dr. Harsha Shantha treated Mr. H. His medical history included sarcoidosis and exposure to coal mine and sand dust. Mr. H. had no history of cigarette smoking. Physical exam of the chest was normal. A pulmonary function test produced evidence of a combined ventilatory defect and a CT scan showed bilateral fibrotic changes in the mid-lung region.³² The findings reported are consistent with sarcoidosis and fibrosis. Dr. Shantha concluded that Mr. H.'s symptoms were related to a combination of sarcoidosis with a restrictive lung disease which has been stable and an obstructive component from coal workers' pneumoconiosis. Mr. H. was being treated for his breathing problems with an inhaler and bronchodilator therapy.

On June 13, 2002, Dr. Mehta again evaluated Mr. H.'s pulmonary condition. The physician reported Mr. H.'s belief that he had been diagnosed with sarcoidosis but the physician noted that such a diagnosis had not been fully confirmed. A chest exam showed bilateral expiratory wheezing and prolonged expiratory phase. The diagnosis included COPD (chronic obstructive pulmonary disease) which could be consistent with pneumoconiosis. Radiographic evidence in the past is also consistent with pneumoconiosis and/or sarcoidosis.

On November 11, 2002, Mr. H.'s pulmonary condition was evaluated by Dr. Mehta. A physical exam of the chest showed that it was normal. The physician diagnosed black lung disease, sarcoidosis, and some lung fibrosis.

On November 24, 2003, Mr. H. reported coughing, shortness of breath, and minimal wheezing during his follow-up evaluation with Dr. Mehta. The x-ray showed bilateral pulmonary infiltrates with changes consistent with pneumonia or sarcoidosis or pneumoconiosis.

On January 2, 2004, a new CT scan showed worsening interstitial process. Mr. H. continued to report coughing and shortness of breath. The results of his pulmonary function tests were progressively worsening. Based on the CT scan, Dr. Mehta believed Mr. H. suffers from progressive coal workers' pneumoconiosis or severe lung fibrosis from interstitial fibrosis. The chest exam revealed bilateral few basilar rales. Dr. Mehta concluded that Mr. H. had COPD, coal workers' pneumoconiosis ("CWP"), history of sarcoidosis, progressive pulmonary fibrosis, and "etiology could be CWP [versus] idiopathic pulmonary fibrosis."

Dr. Mehta reviewed the January 14, 2004 lung biopsy results and examined Mr. H. again on January 23, 2004. The chest exam was normal. Dr. Mehta concluded that Mr. H. "seems to have lung fibrosis." He found no clear evidence of sarcoidosis. Dr. Mehta then opined that the diagnosis should be idiopathic pulmonary fibrosis or coal workers' pneumoconiosis.

Discussion

Of the four physicians who evaluated Mr. H.'s pulmonary condition, two doctors diagnosed either complicated pneumoconiosis or progressive massive fibrosis. Dr. Forehand based his conclusion that Mr. H. has complicated pneumoconiosis on radiographic evidence of large opacities and Mr. H.'s coal dust exposure. At the same time, Dr. Forehand suggested that

³²Based on the nearly contemporaneous dates, and Dr. Shantha's comments about the CT scan, I believe Dr. Shantha is referring to the February 27, 2002 CT scan interpretation by Dr. Stevens.

malignancy and tuberculosis should be ruled out. Concerning these later two possibilities, a January 2004 lung biopsy did not produce any evidence of malignancy. Similarly, the medical record fails to establish that Mr. H. presently has or had tuberculosis.

Similarly, Dr. Rasmussen found the radiographic evidence to be consistent with complicated pneumoconiosis, resulting from coal mine employment. Further, Dr. Rasmussen opined that the only risk factor Mr. H. had is his coal dust exposure, which resulted in progressive massive fibrosis. However, as previously discussed in the evidence section, due to his reliance on Dr. Patel's inadmissible chest x-ray interpretation, and as directed by the Board in *Harris*, Dr. Rasmussen's diagnosis of complicated pneumoconiosis has diminished probative value.

During his initial evaluations of Mr. H. in early 2001 and 2002, Dr. Mehta diagnosed sarcoidosis, pneumoconiosis and mild COPD (chronic obstructive pulmonary disease)/asthma initially. However, after noting that the sarcoidosis diagnosis had never been confirmed and upon consideration of a 2004 CT scan showing a worsening interstitial process and a 2004 biopsy, Dr. Mehta eliminated sarcoidosis as an active diagnosis and concluded Mr. H. had idiopathic pulmonary fibrosis or coal workers' pneumoconiosis. While he did not specifically diagnose complicated pneumoconiosis and expressed uncertainty whether the fibrosis was idiopathic or coal workers' pneumoconiosis, Dr. Mehta's assessment still has significant probative value relating to the possible diagnoses of sarcoidosis, granulomas, and tumor. During his treatment of Mr. H.'s breathing problem and upon the completion of diagnostic CT scans and a lung biopsy, Dr. Mehta essentially eliminated the diagnosis of sarcoidosis and referenced the biopsy report which also highlighted the absence of granulomas in the lung tissue. The same biopsy sample did not contain any malignant tumor cells.

Upon the one occasion he treated Mr. H., Dr. Shantha believed Mr. H. struggled with both sarcoidosis and coal workers' pneumoconiosis. His dual diagnoses presents sarcoidosis rather than pneumoconiosis as an explanation for the presence of the large opacities. However, his diagnosis of sarcoidosis is offset by Dr. Forehand's diagnosis of complicated pneumoconiosis, coupled with Dr. Mehta's conclusion that Mr. H. does not have sarcoidosis.

In summary, the preponderance of medical opinion does not impeach a finding of complicated pneumoconiosis based on radiographic images of large opacities. After setting aside the diminished assessment by Dr. Rasmussen, the conclusions of Dr. Forehand and Dr. Mehta outweigh Dr. Shanta's finding of sarcoidosis. Additionally, Dr. Forehand's certain conclusion that Mr. H. has complicated pneumoconiosis is more probative than Dr. Mehta's equivocal dual etiology of idiopathic fibrosis or coal workers' pneumoconiosis. Accordingly, the preponderance of the probative medical opinion on whether Mr. H. has complicated coal workers' pneumoconiosis supports, rather than contradicts, its presence.

F. Chest X-Ray Comments

In his interpretation of the February 15, 2002 chest x-ray, Dr. Ebeo attributed the noted fibrosis to sarcoidosis. However, since Dr. Ebeo did not also note the presence of a large

pulmonary opacity, his interpretation has diminished probative value in identifying the cause of the large masses established by the preponderance of the radiographic evidence.

In the comment section of his interpretations of the February 15, 2002 and October 3, 2002 chest x-rays, Dr. Wheeler attributed two possible etiologies for the large opacities: conglomerate granulomatous disease or coal workers' pneumoconiosis. In terms of probative value, those comments have little weight as contrary evidence of complicated pneumoconiosis for two reasons. First, in presenting due alternative etiologies, Dr. Wheeler has essentially presented an equivocal opinion on the nature of the large pulmonary opacities. Second, Dr. Wheeler did not review the subsequent CT scans establishing the presence of an interstitial lung disease and a lung biopsy report which noted the absence of granulomas.

Similarly, in his October 3, 2002 chest x-ray comments, Dr. Scott indicated the radiographic changes could be due to TB or an unknown activity. In terms of probative value, those comments have little weight in terms of contrary evidence of complicated pneumoconiosis for three reasons. First, by presenting dual explanations, including an "unknown" process, Dr. Scott is basically stating that he does not know the cause of the large opacities. Such an equivocal position is not sufficient contrary evidence. Second, the subsequent lung biopsy and CT scans, establishing the presence of a worsening interstitial lung disease, which Dr. Scott did not review, failed to identify any previously "unknown" process that might explain the pulmonary masses. Third, the medical record contains no evidence that Mr. H. ever struggled with tuberculosis.

Finally, Dr. Mehta reported the presence of sarcoidosis or pneumoconiosis in the November 2003 chest x-ray. However, his dual etiology interpretations are equivocal. Additionally, after further tests in 2004, Dr. Mehta no longer believed Mr. H. had sarcoidosis.

Conclusion

If chest x-rays vividly establish the presence of large pulmonary opacities as defined by the Act, the invocation of the presumption under 20 C.F.R. § 718.304 is appropriate if the other medical evidence does not establish that either a) the large opacities are not actually present; or, b) another etiology is responsible for the presence of the masses, which is unrelated to exposure to coal dust. Upon my review of the entire medical record developed since 1996, including a lung biopsy, CT scans, pulmonary function tests, arterial blood gas studies, medical opinion and chest x-ray comments, I find insufficient contrary evidence that a pathology unrelated to coal mine dust is the cause of Mr. H.'s large pulmonary opacities. Additionally, the anthracotic and macrophages identified in the lung biopsy, the progressively worsening pulmonary fibrosis observed by Dr. Gunter by comparing the two recent CT scans, and the probative medical opinion by Dr. Forehand supports a finding of complicated coal workers' pneumoconiosis. Accordingly, I conclude Mr. H. is able to invoke the irrebuttable presumption under 20 C.F.R. § 718.304 that he is totally disabled due to pneumoconiosis through: a) the presence of large opacities in the February 15, 2002, October 3, 2002, and December 8, 2003 chest x-rays; b) the absence of sufficient contrary medical evidence showing that large opacities are due to another cause unrelated to coal dust exposure; and, c) biopsy, CT scan, and probative medical opinion findings supportive of a diagnosis of complicated pneumoconiosis.

Concerning the present second claim, through the invocation of the 20 C.F.R. § 718.304 presumption, Mr. H. has proven that he has become totally disabled due to pneumoconiosis, which in turn establishes that since the denial of his prior claim Mr. H. has developed pneumoconiosis, thereby establishing one of the conditions of entitlement that he previously failed to prove. As a result, under 20 C.F.R. § 725.309, I must now examine the entire medical record to determine whether Mr. H. is entitled to black lung disability benefits.

Issue #2 – Entitlement to Benefits

As previously discussed, to receive benefits under the Act, Mr. H. must prove that he has pneumoconiosis, arising out of his coal mine employment; and, that he is totally disabled due to coal workers' pneumoconiosis.

Presence of Pneumoconiosis

Once again, under 20 C.F.R. § 718.202(a)(1)–(4), Mr. H. may establish the presence of pneumoconiosis through regulatory presumption, chest x-rays, biopsy, and medical opinion.

Regulatory Presumption - Complicated Pneumoconiosis

Upon consideration the entire record, I note that the radiographic record from the earlier claim, of 1992 through 1994, provided some evidence of large pulmonary opacities, and produced conflicting interpretations of whether the large nodules were due to pneumoconiosis or sarcoidosis.³³ Additionally, the predominant medical opinion in the early 1990s³⁴ was that Mr. H had sarcoidosis and not coal workers' pneumoconiosis. However, for two reasons, I consider that decade old medical evidence the have diminished probative value on whether Mr. H. now has complicated pneumoconiosis. First, and principally, given the progressive and latent nature of pneumoconiosis as defined in 20 C.F.R. § 718.201(c), the more probative medical evidence on the present condition of Mr. H.'s lungs are the chest x-rays, CT scans, biopsy, and medical opinion developed from 2002 through 2004.³⁵ Second, to the extent that the earlier 1990s medical evidence established the presence of sarcoidosis and the absence of pneumoconiosis, those findings do not preclude Mr. H.'s development of complicated pneumoconiosis ten years later.

³³Dr. Spitz (either complicated pneumoconiosis or sarcoidosis), Dr. Fraser (consolidation consistent with sarcoidosis), Dr. Gammal (bilateral sarcoidosis), Dr. Russakoff (sarcoidosis), Dr. Sargent (coal workers' pneumoconiosis, coalescence of small opacities), Dr. Cole (coal workers' pneumoconiosis, coalescence of small opacities), Dr. Branscomb (large opacities consistent with sarcoidosis), Dr. Parikh (sarcoidosis), Dr. Mehta (sarcoidosis and coal workers' pneumoconiosis).

³⁴Dr. Harding, Dr. Deaton, Dr. Russakoff, Dr. Wheeler, Dr. Caffrey, and Dr. Branscomb concluded Mr. H. had sarcoidosis rather than coal workers' pneumoconiosis. Only Dr. Mehta continued to include both sarcoidosis and coal workers' pneumoconiosis as pulmonary diagnoses.

³⁵See also *Parsons v. Wolf Creek Collieries*, 23 B.L.R. 1-29 (2004) (en banc) (the potential for progressivity and latency of pneumoconiosis is inherent in every case); *Workman v Eastern Assoc. Coal Corp.*, 23 B.L.R. 1-22 (2004) (order on recon.) (en banc).

As previously discussed, I have determined that the preponderance of most recent radiographic films establishes the presence of large pulmonary opacities. Further, the most recent medical evidence does not present sufficient contrary evidence that the large opacities are not due to pneumoconiosis. And, finally the preponderance of the recent, probative medical opinion, in conjunction with two CT scans in 2002 and 2003 and a recent lung biopsy sample support a finding that Mr. H. has complicated pneumoconiosis. Accordingly, under 20 C.F.R. § 718.304, Mr. H. has established the presence of complicated pneumoconiosis.

Pneumoconiosis Arising Out of Coal Mine Employment

Having proven the presence of complicated pneumoconiosis, Mr. H. must next establish that his pneumoconiosis arose, at least in part, out of coal mine employment. According to 20 C.F.R. § 718.203(b), if a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment. Mr. H. has at least 18 years of coal mine employment. As a result, he is entitled to the regulatory presumption.

Because the presumption of pneumoconiosis arising out of coal mine employment is rebuttable, I must reexamine the medical record to determine whether sufficient evidence exists to sever the presumptive connection between Mr. H.'s pneumoconiosis and his coal mine employment. As a starting position, I again emphasize that while the 1990s medical evidence pointed to sarcoidosis as the cause of Mr. H.'s pulmonary impairment, the more probative medical evidence was developed between 2002 and 2004. The newly submitted medical evidence establishes the permanent presence of large opacities in Mr. H.'s lungs related to pneumoconiosis, rather than sarcoidosis.

Considering Mr. H.'s non-existent cigarette smoking history and 18 years of coal mine employment, and based on their pulmonary evaluations, both Dr. Forehand and Dr. Rasmussen specifically attribute the pneumoconiosis present in Mr. H.'s lungs to his exposure to coal dust. While Dr. Mehta was less certain and did not definitively identify coal dust as the cause of the pneumoconiosis, his less-than-certain conclusions about the etiology of the pneumoconiosis are insufficient to rebut the regulatory causation presumption. Other etiologies were also recently raised by Dr. Ebeo, Dr. Scott, Dr. Shantha, and Dr. Wheeler. However, for the reasons previously discussed, I found those potential diagnoses insufficient to attribute the large masses in Mr. H.'s chest to some pulmonary irritant other than coal dust. Accordingly, the causation presumption under 20 C.F.R. § 718.203(b) has not been rebutted and I find Mr. H.'s complicated pneumoconiosis is due to his coal mine employment.

Total Disability and Total Disability Due to Pneumoconiosis

The last two requisite elements of entitlement are total disability and total disability due to coal workers' pneumoconiosis. The medical tests and opinion from the 1990s contained conflicting evidence on the nature and cause of Mr. H.'s pulmonary impairment. However, based on the most recent and probative medical evidence, in conjunction with the coal mine employment causation presumption under 20 C.F.R. § 718.203(b), Mr. H. has proven the presence of complicated coal workers' pneumoconiosis thereby invoking the 20 C.F.R. §

718.304 irrebuttable presumption that he is totally disabled due to coal workers' pneumoconiosis.

Conclusion

Having established all four requisite elements of entitlement, I find that Mr. H. is entitled to black lung disability benefits under the Act.

Date of Entitlement

Under 20 C.F.R. § 725.503(b) in the case of a coal miner who is totally disabled due to pneumoconiosis, benefits are payable from the month of onset of total disability. When the evidence does not establish when the onset of total disability occurred, then benefits are payable starting the month the claim was filed. The BRB has placed the burden on the miner to demonstrate the onset of total disability. *Johnson v. Director, OWCP*, 1 B.L.R. 1-600 (1978). Placing that burden on the claimant makes sense, especially if the miner believes his total disability arose prior to the date he filed his claim. In that case, failure to prove a date of onset earlier than the date of the claim means the claimant receives benefits only from the date the claim was filed. The BRB also stated in *Johnson*, “[c]learly the date of filing is the preferred date of onset unless evidence to the contrary is presented.”

At the same time, a miner may not receive benefits for the period of time after the claim filing date during which he was not totally disabled. *Lykins v. Director, OWCP*, 12 B.L.R. 1-181, 1-183 (1989). This principle may come into play if evidence indicates there was a period of time after the filing of the claim during which the miner was not totally disabled. One example is the situation in *Rochester and Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600 (3d Cir. 1989) where after the miner filed his claim, the initial probative medical opinions provided some evidence that the miner was not totally disabled, yet the administrative law judge found a subsequent evaluation did establish total disability and then set the entitlement date as the date of the claim. The appellate court affirmed the finding of total disability but believed the administrative law judge erred by awarding benefits from the date of the claim because he had not considered whether the earlier medical evaluations indicated that the pneumoconiosis had not yet progressed to a totally disabling stage. In other words, if evidence shows an identifiable period of time where a miner was not totally disabled by pneumoconiosis that is subsequent to the date the miner filed his claim and prior to a firm medical determination of total disability, then it is inappropriate to award benefits from the month the claim was filed.

However, if no intervening medical evidence raises the possibility of total disability not being present between the claim filing date and the first medical evaluation establishing total disability, then a different set of principles is applicable. In this situation, when the first medical examination after the claim is filed leads to a finding of total disability, the date of the examination does not necessarily establish the month of onset of total disability. Instead, it only indicates that some time prior to the exam, the miner became totally disabled. See *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1985) (the date the claimant is “first able to muster evidence of total disability is not necessarily the date of onset”).

In its remand order, having vacated several of my determinations, the BRB also directed that I reconsider date of entitlement of February 1, 2002 if I concluded Mr. H. was entitled to benefits. On remand, the Employer asserts the date of entitlement should be no earlier than the month Mr. H. filed his second claim, July 2002, because the supportive diagnoses occurred after that date.

Upon reconsideration, I note that Mr. H. was unable to prove the presence of complicated coal workers' pneumoconiosis in his first claim and did not present any medical evidence for the period between 1996 and early 2002. Contrary to the Employer's assertion, the first definitive evidence of complicated pneumoconiosis is the chest x-ray taken in February 2002, which I have concluded shows a large pulmonary opacity attributable to pneumoconiosis. In the absence of any other post-1996 medical evidence, I find the February 2002 radiographic study, which predates the July 2002 filing date of his second claim, establishes that by February 2002 Mr. H. developed complicated coal workers' pneumoconiosis and correspondingly become totally disabled due to coal workers' pneumoconiosis. As a result, Mr. H.'s black lung disability benefits are payable beginning February 1, 2002.

Augmentation

Benefits under the Act may be augmented for a person who meets the criteria of spouse under 20 C.F.R. § 725.204 and the dependency requirements of 20 C.F.R. § 725.205. In light of my preliminary determinations, I find that Mrs. C.H. is a qualified spouse, meeting the regulatory requirements for spousal augmentation of Mr. H.'s black lung disability benefits.

Attorney Fees

In September 2005, I approved \$7,012.50 in attorney fees for Claimant's counsel contingent upon a final and successful prosecution of Mr. H.'s claim for black lung disability benefits. In its remand decision, the BRB approved my attorney fee determination.

In regards to the present remand, Counsel for the Claimant has thirty days from receipt of this decision to submit an additional application for attorney fees in accordance with 20 C.F.R. §§ 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including Claimant. The other parties have fifteen days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with the claim.

ORDER

The claim of MR. D.R.H. for benefits under the Act is **GRANTED**. COWIN AND COMPANY, INC. is ordered to:

1. Pay Mr. D.R.H. all benefits to which he is entitled under the Act and Regulations. Benefits shall commence February 1, 2002, augmented for his spouse Mrs. C.H.
2. Reimburse the Black Lung Disability Trust Fund, pursuant to 20 C.F.R. § 725.602(a), for all interim payments made by the Black Lung Disability Trust Fund to Mr. D.H.;
3. Deduct from the payments ordered in paragraph one, as appropriate, the amounts reimbursed to the Black Lung Disability Trust Fund as directed in paragraph two; and
4. Pay to the Secretary of Labor interest as required pursuant to 20 C.F.R. § 725.608(b).

SO ORDERED:

A
RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: August 15, 2007
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties

Certification:

David Soike, MD

Certified by the American Board of Pathology in:

Anatomic Pathology and Clinical Pathology

American Board of Medical Specialties

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[HTTP://www.abms.org](http://www.abms.org)

Attachment No. 2

American Board of Medical Specialties

Certification:

Randolph J. Forehand, MD

Certified by the American Board of Allergy and Immunology in:

Pediatrics, Allergy and Immunology

American Board of Medical Specialties

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